Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $111,412.50, according to the position statement submitted by the Requestor's representative for date of service 09/05/01.

   b. The request was received on 06/05/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/25/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/26/02. The response from the insurance carrier was received in the Division on 09/04/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Letter requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   "TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the *entire admission*, after a Carrier audits a bill. See Tex. Admin. Code Section 133.401 (c). The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services which are not related to the compensable injury. At that time, if the total audited charges *for the entire admission* are below $40,000, the Carrier may reimburse at

a 'per diem' rate for the hospital services. However, if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission.'… The only audited charge that was not reimbursed per the Fee Guideline was Revenue Codes[sic] 278. In accordance with the TWCC Rules and QRL 01-03, the facility requests reimbursement of 75% of audited charges. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **$111,412.50, plus interest.** Please note that the Carrier response states that payment was made, however, as of this date, no further payment for Revenue code 278 has been made."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 09/05/01.

2. The Provider billed the Carrier $148,550.00 for the implantables, for the date of service 09/05/01.

3. The Carrier made a total reimbursement of $0.00 for the implantables, for the date of service 09/05/01.

4. The amount left in dispute for the implantables, is $111,412.50.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation submitted by the Requestor indicates that the total charge for the implantables was $148,550.00. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier paid $0.00 for the implants. The Carrier denied the implantables with the denial codes of "N-NOT DOCUMENTED-IN ORDER TO REVIEW THIS CHARGE WE NEED A COPY OF THE INVOICE DETAILING COST TO PROVIDER. M-REIMBURSEMENT BASED UPON "FAIR AND REASONABLE." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the TWCC Rules, since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate the reason for no reimbursement of the implantables. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

However, review of the evidence from the provider reveals a difference in the number of items billed, and the number of items documented on the operative reports. There is some correlation between the descriptions of items used in the operative report to the description of the items in the invoice. There is however, no description identifying the same items on the hospital's itemized statement that correlates the usual and customary charge. For this reason, it is difficult to apply the stop-loss methodology to determine proper reimbursement for the documented implantables. Consequently, the Medical Review Division **does not** recommend reimbursement for the charges in dispute.

The above Findings and Decision are hereby issued this 14th day of November 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb